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301 West Grove Street – Suite 2e
Clarks Summit, PA 18411

Thank you for choosing our office to improve and maintain your dental health. Please take a few moments to answer the questions on the following pages. The information provided is necessary and will help us serve you better. Please let us know if we can assist you in any way.

Personal Information:

Date: _____ Patient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Birthdate: _____ Social Security Number: _____ ___Male ___Female
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Information:

Emergency Contact: _____ Phone Number: _____ Relationship:_____

Parent / Guardian Information if patient under 18 years old:

__ Mother __ Father __Guardian Name: _____ Phone: _____

Previous Dentist: _____ ***Date of Last Cleaning:*** _____

Whom may we thank for referring you? _____

Insurance Information:

Insurance Company: _____ Subscriber Name: _____
Patient Relationship to Subscriber: _____ Insured's Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip:_____
Insured's Social Security Number: _____ Insured's Date of Birth: _____
Member ID Number: _____ Group Number: _____

Secondary Insurance Information:

Insurance Company: _____ Subscriber Name: _____
Patient Relationship to Subscriber: _____ Insured's Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Insured's Social Security Number: _____ Insured's Date of Birth_____
Member ID Number: _____ Group Number: _____

Patient's Name:_____

Consent for Use and Disclosure of Healthcare Information:

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. We encourage you to read our Notice carefully and completely before signing this consent. We reserve the right to change our privacy practices. We will issue a revised Privacy Practices, which will contain the changes. By contacting the office, you may request a copy of our Notice at any time you have the right to revoke this consent at any time by giving us written notice of your revocation. We may decline to treat you if you revoke this consent.

Signature:_____Date:_____

If consent is signed by a personal representative on behalf of the patient, please provide the following:
Representative name:_____Relationship to patient:_____

Financial Policy:

We bill and accept most insurance plans. We participate with several insurance carriers and follow the criteria of those carriers, yet due to limitless variations and exclusions of insurance plans, we do not participate with all plans or carriers. This means that the patient is responsible for any balance that remains after insurance payment. I agree to be responsible for the payment of all services rendered on my behalf or dependent's behalf. I authorize and request my insurance to pay directly to the dentist insurance benefits otherwise payable to me. Failure to keep account current may result in the dentist being unable to provide additional services except for dental emergencies. In the event of default on payment of account, I agree to pay collections costs and fees incurred in attempting to collect on delinquent account balance.

Signature:_____Date:_____

If consent is signed by a personal representative on behalf of the patient, please provide the following:
Representative name:_____Relationship to patient:_____

Rescheduling of Appointments:

I understand that appointment time is very valuable and 24 hours notice must be given for rescheduling or cancelling appointments. I understand a $50 fee may be charged to me at the office's discretion is 24 hour notice is not given. I understand that three failed appointments may result in termination of my patient status.

Signature:_____Date:_____

If consent is signed by a personal representative on behalf of the patient, please provide the following:
Representative name:_____Relationship to patient:_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____